Q&A Regarding HCBS Providers' Rate Study Reporting Template *10.6.16*

Process Questions

1. Why do we have to do this?
    a. The purpose of this template is to assess the adequacy of the Medicaid rates for Kansas' HCBS Waiver services.
2. Who exactly is requiring this rate study? You are stating that the "State" is requesting this information. Which branch?
    a. The Kansas Department of Health and Environment (KDHE) has contracted with Optumas, an actuarial consulting firm, to assess the adequacy of HCBS payment rates.
3. Why don't we just send you our tax return?
    a. To keep information consistent across providers and properly assess the adequacy of the HCBS payment rates, we are looking for the information specifically requested on this template. We would be happy to receive any documentation in addition to the completed template.
4. So on the taxes return what address do we sent them to. Thanks.
    a. Tax returns and any additional documentation should be emailed to chris.dickerson@optumas.com and tim.doyle@optumas.com. Alternatively, a hardcopy may be mailed to Optumas at 7400 E. McDonald Dr. Suite 101, Scottsdale, AZ 85250.
5. The rates for the TBI waiver have not been increased since 1993. How will that be factored in?
    a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas' HCBS Waiver programs as they currently stand. We welcome any comments that could assist in this goal on tab |5. Comments| in the template.
6. How will you take into account the number of people not utilizing all authorized hours because they cannot find people for the rates available
    a. Thank you for raising this concern; we will discuss this further with KDHE and consider this as part of our rate study. We welcome additional comments that could assist our goal of assessing rate adequacy on tab |5. Comments| in the template.
7. Is outside revenue considered by CMS in the rate setting process? What is the intent of providing this information for this study?
    a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas' HCBS Waiver programs. We are considering all related information to assist this goal. We have included non-Medicaid revenue and expenses on this template with the goal of having tab |4. Summary| tie to your organization's financial reporting.
8. The IDD waiver has recently reported revenue and expenses by service in a rate study. Why is this information not being used?
    a. Optumas has been contracted to conduct a study of rate adequacy for Kansas' HCBS services. The information requested in this template is necessary to conduct this study and our process is completely independent to the previous study.

9. Where can we access the recording of the template walkthrough webinar?
    a. The recording of the template walkthrough webinar is posted on KanCare's website, both on the home page and the provider events page. The direct link to the recording is https://www.youtube.com/embed/3HANQybp-AU?rel=0
10. What is the formula you will be using for rates? Will you even change rates based on these questions? Will you be using any national rate studies or will you be making this up yourself?
    a. We will be considering multiple sources of data for our final report. The data received from providers in this template will account for a substantial portion of the study. Optumas will convey findings to the State and rate change policy decisions will be at the State's discretion.
11. How will this template be provided to providers?
    a. A notice about the template and access instructions were sent to providers by KDHE on 9/23/2016 and is available online at http://www.kancare.ks.gov/provider_events.htm
12. Is this still due Oct. 17th?
    a. The expectation is for all templates to be returned completed by October 17, 2016 in order to complete the study in an appropriate time.
13. Can we contact you outside of this webinar?
    a. Questions not addressed here or in the review should be emailed to chris.dickerson@optumas.com and tim.doyle@optumas.com.
14. The document says the state policy is to consider outside revenue sources in establishing rates. Is this supplanting the rates approved by CMS?
    a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas HCBS Waiver programs. We are considering all related information to assist toward this goal. Any potential changes to rates will be addressed by the State.
15. What happens if providers miss the deadline by a few days?
    a. Providers are asked to submit the completed template by 10.17.16. If you have a unique situation that causes you to need a brief extension of the deadline, please send a request that explains your situation, and proposes a short-term/specific alternative submission date, to Elizabeth Phelps at KDHE (ephelps@kdheks.gov). Unless a specific, time-limited extension is approved, the October 17th deadline applies.

Feedback

1. We do not have the staff to spend time in this because our rates are inadequate.
    a. The goal of this template is to assess this information on a statewide level. Completing this template will help provide that information and can only help in determining rate adequacy. We developed this template to be a user friendly and efficient way to capture information we thought would already be available to providers.
2. Profit/Loss does not always reflect the Cash position - especially when you take into consideration claims still not paid...
    b. The goal of this template is to assess the adequacy of the Medicaid rates paid for Kansas' HCBS Waiver programs. Given that we are asking for CY14 and CY15 data, and based on our experience with HCBS in other states, the bulk of the claims should be paid for these time periods. Please provide figures on an accrual/incurred basis, which would account for any claims not yet paid.

As discussed on the call, Optumas will validate the revenue reported based on the data available.

3. Clients that have waivers - Medicare does not cover their waiver services
    a. We are in agreement that waiver services are primarily Medicaid responsibility, but understand that organizations may also provide other services paid by Medicare or other insurance. Non-Medicaid revenue can be reported in cells C23:D29 on tab |1. Revenue|, separate from waiver service revenue.
4. Recently there were significant budget cuts in the CMHC system that won't be reflected on this template.
    a. We welcome any comments that could assist in determining adequacy of HCBS payment rates on the tab |5. Comments| in the template. These comments will be assessed carefully, and additional adjustments may be applied to the base data in order to account for such instances.

Patients and Visits

1. What is a Unique Medicaid pt.?
    a. A unique Medicaid patient is an unduplicated count of individuals who received Medicaid services. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the |3. Services Rendered| tab, cell C11 should have "1" and cell C27 should have "12".
2. How would you like me to count Unique Patients if they spilt between HCBS and Non-Medicaid. IE if they were approved in the middle of the year?
    a. Under this scenario, we would like the individual to count once in the Non-Medicaid table and once in the Medicaid table.
3. How do you define a visit for HCBS services? Is there a certain number of hours per visit? Curious if is 1 for each encounter or based on billed units? HCBS day and res services and SHC are tracked in different kind of units (days, 15 min units). How do you suggest we report these units in the visits section? Unclear and does not match how billing is conducted for IDD waiver. For a Day Service, would it be how many days one person attended or how many units?
    a. For the purposes of this study, a visit is a patient encounter (either in-person or virtual). It should not be billed units, as different services have a wide range of unit values. Instead, we would like to see the count of patient interactions, which are sometimes considered patient-days. For example, if a provider has a residential patient that they see every day of the month, we would like that individual to count as 30 (or 31) visits in the given month. If a provider has a patient that receives services one day a week, we would like each of those weekly encounters to count as one visit, regardless of whether the patient is given 15 minutes of services or an hour of services.
4. Services Rendered tab - that is asking for a patient count at the top and patient days at the bottom - is that right? Related to above question - for a patient count you want that for our year end, and the patient days for the entire year?
    a. This is correct. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the |3. Services Rendered| tab, cell C11 should have "1" and cell C27 should have "12".

5. Under numbers served, do you want the grand total from each month served? We service the same people each month so if we serve 30 people would that total 30 x 12 months = 360 served?
    a. "Visits" should include the entire year. If you serve 30 people every day for a full year, you would report 30 x 365 = 10,950. "Unique Patients" should be the unduplicated count of patients served. In this example you would report 30.
6. Define "visit" in terms of Day, Residential, and Personal Care Services.
    a. For the purposes of this study a visit is a patient encounter (either in-person or virtual). It should not be billed units, as different services have a wide range of unit values. Instead, we would like to see the count of patient interactions, which are sometimes considered patient-days. For example, if a provider has a residential patient that they see every day of the month, we would like that individual to count as 30 (or 31) visits in a month. If a provider has a patient that receives services one day a week, we would like each of those weekly encounters to count as one visit, regardless of if the patient is given 15 minutes of services or an hour of services.
7. By "patient" do you mean MCO Member?
    a. A patient would be anyone receiving HCBS services. They could be enrolled in a Medicaid MCO, Medicaid FFS, or for the non-Medicaid tables, they could be commercial/Medicare/private pay.
8. If a person private pays for day service, is that a non-HCBS service?
    a. Revenue received from a private pay patient or commercial insurance plan can be reported on tab |1. Revenue| in rows 24 and 25 ("Commercial", "Patient Payment"). Visits and patient counts would be reported in the non-Medicaid table on |3. Services Rendered|. Whether it is considered HCBS or non-HCBS would depend on the specific service provided.
9. Under the Unique Medicaid not unique category are you wanting number of patients or what?
    a. Tab |3. Services Rendered| should include Medicaid data on the left tables, with the number of patients in the top table and the number of visits in the bottom table. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the |3. Services Rendered| tab, cell C11 should have "1" and cell C27 should have "12".
10. tcm's do not bill only for visits but a billable service. how do I answer the # visits?
    a. We request that you complete this to the best of your ability. If possible, please report the number of days of service provided to each patient.

Applicable Providers

1. Does this apply to SED waiver? We are not CDDOs, nor affiliated with CDDOs.
    a. All providers of services under any of Kansas' seven waivers are requested to report their information using this template. The space created on the |Instructions| tab for declaring CDDO affiliation does not necessarily apply to all such providers, and should be left blank when no arrangement of this type exists.
2. Do Targeted Case Managers for the IDD waiver have to participate in this study?
    a. All providers of services under any of Kansas' seven waivers are requested to report their information using this template. If a provider's services are limited to Targeted

Case Management, which is a State Plan service, the provider does not have to submit the template.

3. If an agency provides the "pay and bill" function for several independent Autism providers, can we complete one report for those individual workers?
    a. If billing and reimbursement occur through a single entity with one NPI, then the information for independent providers may be reported using a single template. If billing and reimbursement occur through multiple NPIs, the template should be completed for each NPI.
4. We received a request to complete the survey for our foster care services. Should we submit the survey for this non-HCBS service?
    a. This template includes cells for reporting revenue and expenses for non-HCBS waiver services in addition to HCBS waiver services. If your organization provides HCBS services, please fill out the template with HCBS revenues, expenses, and services in the HCBS rows, and non-HCBS information in non-HCBS rows. If your organization does not provide services under any of Kansas' seven waivers, then there is no need to complete the template.
5. My company runs a nursing home, senior apartments, and a community center. Do I report revenue and expenses for all three?
    a. If all of your locations operate with the same NPI, they should all be included on the same template. The goal of this template is to create a complete picture of revenue and expenses for your organization. You are requested to provide all pertinent information related to the operation of your organization to help us achieve this goal. Please be as specific as possible when categorizing revenue and expenses, as this will help us understand all lines of business and how HCBS waiver services fit into that overall picture.

Revenue & Expense

1. Why are you requesting revenue data, when what you need to be looking at is cost in order to determine if the rates paid currently are adequate and are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers?
    a. We plan on looking at both revenue and cost. The goal of the rate study is to determine if rates are adequate to cover the cost of services provided. By collecting data on the revenue received from these rates and the cost of the corresponding services we can make statements regarding rate adequacy.
2. Should the revenue include just the Waiver specific codes or revenue for all codes the Waiver participant receives?
    a. Please include Medicaid revenue for Waiver services in lines 10 through 17 of the |1. Revenue| tab. If a member receives non-Waiver services (e.g. Physical Therapy), please include that Medicaid revenue in line 18 of the |1. Revenue| tab.
3. Revenue for the year would only include (Dates of Services) for that Calendar year. So If I received revenue for 2013 in 2014, I would not include that in the 2014 revenue?
    a. Revenue should be reported based on the date of service, so a service provided on 12/31/13 that is paid on 1/15/14 would not be reported for 2014.

4. For the Medicare payment are you saying that we you want the Medicare B income for those years? Even if they do no pertain to HCBS residents?
    a. The Medicare revenue line is intended to capture any revenue your organization receives from Medicare. Optumas is most concerned with matching revenue and expense. If you can split your revenue *and* expenses to exclude just the Medicare part B components that is appropriate. If you are unable to split the information, we ask that you report all revenue and expenses in as detailed a manner as possible to allow us additional insight to your company's operations.
5. Do we need to be consistent on how we report revenues vs expenses. For ex if we can breakdown revenues but not expenses which way should we report?
    a. Please be as detailed as possible. If revenue can be split into greater detail than expenses, split revenue into detail and report expenses as you can.
6. On tab 2, line 25: the Parent Fee is sent directly to the State, not the provider. Do you mean Client Obligation which is sent to the provider of service?
    a. Parent Fee is meant to capture any payments made from a subsidiary to a parent company or corporation.
7. The instructions say accrual basis, but in the Revenue tab in instructions it states "payments made to your provider ID". Do you want revenue earned, or payments received?
    a. Report the revenue earned, regardless if payment has been received yet.
8. Is this for Gross Revenue or Net Revenue?
    a. Please report the revenue after adjusting for recoupments.
9. There is no place on this report for adjustments. How do we account for this?
    a. Please report revenue after adjustments. If you receive $100, but $20 is recouped, please report $80. Any additional revenue, expenses, or services that cannot be included in the splits should be included in the general categories ("Other Revenue", "Non-Service, Non-Admin Expenses" etc.) with explanations below.
10. For revenues, do we include all service codes or just Waiver specific codes?
    a. Please report Medicaid revenue for waiver specific codes in lines 10 through 17. Medicaid revenue for non-waiver codes should be reported in line 18. In addition, non-Medicaid revenue is captured in lines 23-29.
11. Does the category of service expense include indirect care such as dietary, housekeeping, laundry, etc. Should property expense be included in operation expense?
    a. The indirect services mentioned should be considered waiver expenses and should be categorized in lines 8 through 15 of the |2. Expenses| tab as appropriate. Property expenses should be included in "Operations Expenses", line 22 of the |2. Expenses| tab.
12. As A CCRC, it is assumed that the revenue/expenses that are needed include only the home health/hcbs and not the entire organization services at every level of living
    a. Optumas is most concerned with matching revenue and expense. If you can split your revenue and expenses to include just the home health and HCBS components in the template that is appropriate. If you are unable to split the information, we ask that you report all revenue and expenses in as detailed a manner as possible to allow us additional insight to your company's operations. Please note that since home health services are covered under the state plan they should be reported in the "Non-HCBS Service" lines.

13. Many of the grants or fund raisers providers do are specifically tied to a certain activity and aren't available for overall operations. Where would you like them entered? In the comments section?
    a. Please enter revenue tied to a specific activity in row 29 of the |1. Revenue| tab, and explain all components of the revenue in the comment box.

Information to Include

1. We bill HCBS for our Home Health and separately for our Assisted Living. What is the focus of the template? Do we have to do both?
    a. The purpose of this template is to assess the adequacy of rates paid for all services under each of Kansas' seven waivers. You are requested to provide all pertinent information related to the operation of your organization. Please be as specific as possible when categorizing revenue and expenses, as this will help us understand all lines of business and how HCBS waiver services fit into that overall picture. Please note that since home health services are covered under the state plan they should be reported in the "Non-HCBS Service" lines.
2. Is this for services rendered in the state of Kansas only?
    a. You are requested to provide information for all Kansas HCBS waiver enrollees, whether services are rendered in Kansas or another state.
3. If 2014 information was already provided in the earlier rate study, do we need to re-submit?
    a. Yes. The intent of this template is to gather information that is consistent across all HCBS provider types.
4. Can we report on fiscal year 2014 and 2015, not calendar years? Converting it to calendar year will not tie to anything and would be time prohibitive to do. Can we just change the certification to note that we are reporting on fiscal year?
    a. All information is requested on a calendar year basis. We apologize for any inconvenience, but aligning the time periods of all submissions is necessary to make valid comparisons.
5. If I am a provider for IDD HCBS residential and day services, when I complete this form, is it only for OUR services? Or do I need to obtain information for all doctor appointments I have taken participants to? All therapy appointments I have taken them to, etc? Is it just strictly residential and day services you want data on for my provider?
    a. Information submitted through this template should be limited to the services provided by your organization and billed through your NPI. Services provided by any separate entities (physicians, therapists, etc.) should be excluded.
6. What if you have one NPI number and multiple Medicaid provider numbers? How does that affect the reporting template?
    a. Please enter your NPI and one Medicaid provider ID on the |Instructions| tab. Additional Medicaid provider IDs and a brief explanation should be submitted using the |5. Comments| tab.
7. I have participated in HCBS waiver services only during 2016. Do you want information from me indicating 0 services and $0?
    a. If your organization did not provide any HCBS waiver services during calendar years 2014 and 2015, then there is no need to complete the template.

8. Can you please go over the multiple locations needing separate worksheets?
    a. The number of worksheets that should be submitted is based on the number of NPIs in use. If your organization consists of multiple locations that bill for services and are reimbursed under a single NPI, then filling out one template will suffice.
9. Is the CDDO required to release the organization's NPI to affiliates or can that field be left blank?
    a. If the NPI is not available for the CDDO with which you are affiliated, please provide the CDDO's name. In this case, the NPI may be left blank.
10. Do you want IDD nursing broken out from IDD personal care assistant, or all together?
    a. Revenue and expense information for services provided under the same waiver may be grouped together for reporting purposes.
11. I have limited clients on HCBS waiver for IDD. Residential and day habilitation services paid through Medicaid waiver funding. Do I lump both residential and day habilitation services? Are expenses to include transportation entertainment day services?
    a. Revenue and expense information for services provided under the same waiver may be grouped together for reporting purposes.
12. SEK 3-B HOMEMAKER; VA Attendant Care; SCA HOMEMAKER. Where would you classify this revenue, client count and visits on your spreadsheet?
    a. These services are not Medicaid funded services, so the revenue for them should be reported in the "Other Revenue" table on the |1. Revenue| tab (cells C23 to D29). Providers can place the revenue in the most appropriate line in that table.